UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

UNITED STATES OF AMERICA,	)	Case No. 2:20-cr-00179-TOR-2
	)	
Plaintiff,	)	October 31, 2024
	)	Spokane, Washington
vs.	)	
	)	Pretrial Proffer Hearing
DANIEL AUGUSTINE SOLIS,	)	
	)	Pages 1 - 55
Defendant.	)	

BEFORE THE HONORABLE THOMAS O. RICE
UNITED STATES DISTRICT COURT JUDGE

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Proceedings reported by mechanical stenography; transcript produced by computer-aided transcription.

(Court convened on October 31, 2024, at 10:02 a.m.)

THE COURTROOM DEPUTY: The matter now before the Court is the *United States of America v. Daniel Augustine Solis*, Case No. 2:20-cr-179-TOR-2. This is the time set for a pretrial proffer hearing.

Counsel, please state your presence for the Court and record.

MS. GREGOIRE: Good morning, your Honor. Alison Gregoire and Rebecca Perez on behalf of the United States.

THE COURT: Good morning.

MS. BAGGETT: Good morning, your Honor. Sandy Baggett for Mr. Solis. Mr. Merritt had a prior scheduling conflict and will not be here today.

THE COURT: And good morning to both of you.

Ms. Baggett, I'll hear from you. You've requested this hearing.

MS. BAGGETT: Yes, your Honor.

Your Honor, if I could proceed by calling Dr. Matthew Layton, our expert witness, to the stand and engage in a question and answer with him. I think that will be the best way to try to answer the Court's questions, more fully explain details of his Rule 16 notice that we previously provided. Is that okay, your Honor?

THE COURT: Proceed.

MS. BAGGETT: Thank you.

Your Honor, I'm just going to apologize that I'm having to use cough drops because I have a bit of a cold.

THE COURT: That's fine.

You can come up on the witness stand, and I'll have you raise your right hand and be sworn by the deputy clerk.

(MATTHEW LAYTON, called as a witness by the Defendant, having first been duly sworn, testified under oath as follows:)

THE COURTROOM DEPUTY: Please state your name, spelling your first and last name for the Court and record.

THE WITNESS: Matthew Eric Layton, M-A-T-T-H-E-W L-A-Y-T-O-N.

THE COURTROOM DEPUTY: Thank you.

THE COURT: Please be seated and use the microphone. It's adjustable.

THE WITNESS: Thank you, your Honor.

MS. BAGGETT: Your Honor, I'm not going to go through in great detail his credentials. For this purpose, I'll rely on his CV, his record of expert testimony, and his publications that were previously filed under the Rule 16 notice, if that's okay with the Court.

THE COURT: Please proceed.

MS. BAGGETT: Thank you.

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DIRECT EXAMINATION

BY MS. BAGGETT:

Q. Dr. Layton, I do want to just go a little bit into your background to the extent that it helps us understand your opinions here today. Can you just -- so you're a psychiatrist, and can you explain basically what a psychiatrist is in the medical world?

A. Yes. I am a psychiatrist, and I went through medical school to get an MD and then had four years of general psychiatry residency training at the University of Washington in Seattle.

Q. And then you're also a toxicologist? Can you explain --

A. Pharmacologist. Sorry for interrupting.

Q. Pharmacologist. Sorry. Pharmacologist.

A. I have a Ph.D. in pharmacology.

Q. Yes. Sorry. And can you explain what a pharmacologist is and why you would also get a Ph.D. in addition to being a medical doctor?

A. The field of pharmacology is the study of the effects of medicines and substances on the body and how the body deals with those substances. And when I was in medical school and decided I wanted to go into psychiatry, it was 1988, and we had very little understanding of the brain and neurosciences, and so I decided to get a Ph.D. in pharmacology, specifically psychopharmacology, to better prepare me to take care of

psychiatric patients.

Q. And can you explain for the Judge, what is psychopharmacology?

A. It's focused in specifically on the pathways within the brain and the central nervous system. The neurotransmitters and the chemicals that interact specifically with different brain parts, that's the psychopharmacology.

Q. Can you just describe what the -- because this term may come up -- what the DSM is?

A. It's the Diagnostic and Statistical Manual of the American Psychiatric Association, and it was originally published in the 1950s with what was called the DSM-1, and we are now to the DSM-5 text revision.

Q. And how is that publication produced?

A. It is from the American Psychiatric Association, and the work groups within the organization address any deficiencies or problems with prior editions or incorporate new findings and especially new evidence that supports the making of a psychiatric diagnosis.

Q. Can you describe for the Judge the materials that you reviewed to prepare your opinion on the -- any evaluations that you made?

A. I reviewed the psychological evaluations by Drs. Low and Guyton, as well as evaluations by Dr. Hail and Muscatel. I also reviewed medical records and social history records from

Mr. Solis, and I interviewed Mr. Solis in person at Sea-Tac back in July.

Q. And when you say you reviewed records of Mr. Solis, did you mean the foster care records?

A. Yes.

Q. From his childhood?

A. Yes.

Q. Did you also review any medical records from jails or prisons?

A. Yes.

Q. And did those postdate his arrest and incarceration in this case?

A. Yes.

Q. And for the purpose of your evaluation, your opinion today, sorry, did you interview anyone else?

A. His biological mother, Mr. Solis' biological mother, Whalen -- Ms. Whalen.

Q. And the materials that you've just described, an in-person evaluation of the subject, reviewing the diagnoses of other psychologists and medical records, are those the typical types of things that a psychiatrist, a pharmacologist would review to form an opinion and diagnosis of a subject like Mr. Solis?

A. Yes.

Q. Can you sort of explain the difference between these two terms "physiological" and "psychological"?

A. Physiology -- physiology is how an organism works, all of the mechanisms that make it work, for example, how blood flows, how nerves work, and the basic natural state. That is the physiology.

The psychology is how the brain thinks about the world and interprets the environment, so it is less easy to measure. We use indirect tests for psychology, as opposed to physiology where you can look at things in a very mechanical way.

Q. Okay. And so for -- to kind of dumb it down for people like me, physiological is like anatomy, like physical things, like the anatomy of the body and chemicals, things that -- you can, like -- that exist, like, physically on the body?

A. Even more specifically, how the anatomy works --

Q. Okay.

A. -- in a functional way.

Q. And for your opinion in this case, would you say it's a physiological opinion or a psychological opinion or a combination of both?

A. It's a combination of both.

Q. Can you describe for the Judge, in your report -- in your notice that we had previously given, you sort of describe certain neural pathways in the brain and systems like that. Could you describe for the Judge those pathways that were important to your opinion in this case in a normal functioning brain?

A. Yes. The -- one of the main neurotransmitters of the brain that a lot of lay people are familiar with is dopamine. Dopamine has multiple pathways in the brain and multiple different kinds of receptors in the brain from where dopamine binds to have its effect. One of the things that people say a lot is they do a pleasurable activity to get a dopamine hit. So, for example, eating chocolate or going for a run or the kinds of things that give people natural pleasure involves dopamine stimulating certain parts of the brain.

What we know now from the clinical side in terms of mental disorders is that too much dopamine then can actually lead to psychotic symptoms, including paranoia, hallucinations, and delusions. And one of the main reasons we know that is the medications that block psychosis -- that help with psychosis block dopamine binding in the brain.

Q. And when you -- so dopamine is like a molecule, like something physical in the body?

A. Yes.

Q. And when you say "receptors," can you describe what a receptor is and where dopamine receptors that are relevant to your opinion in this case -- what part of the brain would those be in?

A. Yes. So a receptor is essentially a protein that is in the membrane of a cell, and in this case, a neuron. So the protein is in the membrane, and the chemical binds and then triggers

downstream intracellular effects. So dopamine has at least four different kinds of receptors, and they're in different parts of the brain. The pleasure center or the reward center has to do with the nucleus accumbens and the ventral tegmental area, but then you also have projections from the cortex that go to those lower brain areas.

Q. When you say once the dopamine sort of combines with the receptor and sticks on there, it creates a cascade of other things in the cell, what kind of other things does it create in the cell?

A. It can turn on intracellular enzymes. It can lead to excitation or inhibition of neighboring neurons, and so when you get down to the basic level, it can even activate DNA transcription, for example.

Q. Can you describe methamphetamine? Is that in a class of drugs and what class is that?

A. The stimulants or further psychostimulants, yes.

Q. What are other psychostimulants?

A. Cocaine, methylphenidate, regular amphetamine, which is a metabolite of methamphetamine. You could argue that caffeine is a stimulant, but it doesn't act through the dopamine pathway the same way.

Q. Okay. So when a person is exposed for -- in whatever way to one of these psychostimulants, what happens in that brain pathway that you just described?

A. The most common thing is that you get a down regulation of dopamine receptors, which means that with excessive stimulation due to something like methamphetamine, which is introduced to the body and the brain from outside, it stimulates those dopamine receptors so much that they decrease, so they get pulled back into the cell. So there are fewer dopamine receptors, and that can happen regardless of how the exposure takes place.

Q. And what's the -- is there any significance to those receptors, a reduction in the number of those receptors?

A. The individual often will try to increase stimulation by taking more of the substance or if they're not in a place to do that, they may have deficits that lead to things like problems thinking, difficulty with sleep, and natural function.

Q. What -- is there any effect on these brain cells and receptors when there is longer-term exposure to one of these kinds of stimulants?

A. Yes. You can go from acute effects to more chronic effects.

Q. And when you say "more chronic effects," what in the brain do you mean by that?

A. The brain gets more and more dysregulated, especially the more it's exposed to higher amounts of whatever the substance is. And therefore, for example, you no longer get a high feeling because you're consuming so much, it tends to be more of

an anxious state or more of a dysphoric state and often leads to staying up for many days to try to achieve some sort of good feeling, but most the time, the chronic state is trying to maintain and not actually feeling the same kind of euphoria as acute.

Q. Okay. So you've used the terms "chronic" and "acute." Can you just explain for the Judge sort of the spectrum of I guess timeline of diseases in that term -- in those terms?

A. If, for example, there was exposure in utero, so while his mother was pregnant, to any substance, it can affect the brain well before the human being has any choice about that. So if, for example, you look at fetal alcohol syndrome or fetal alcohol effect, it's because the baby's brain is exposed to alcohol while the mother is pregnant, and it changes the brain structure and function. It's a similar kind of effect with crack. For example, we talked about crack babies a lot back in the '80s. When the baby is exposed very early, their brain is super sensitive to those impacts on their dopamine pathways.

Q. And why is it that -- so how long -- so there's -- why is it that babies are more sensitive -- why are their brains more sensitive on those dopamine pathways?

A. They're so undeveloped, and the amounts of the chemical that are being exposes to this very small being, small human being, versus a full grown person, you have effects both on the periphery as well as in the brain. And if that exposure

continues over time, then the infant has very little ways to address that. They need nurturing. They need food. They need care. And that's what they're supposed to be getting that will stimulate the brain. Nutrition, they need nutrition. That's what's supposed to stimulate the brain to develop normally, but when they're exposed to substances early on, their brain doesn't get that chance to develop normally, and also are not getting the nurturing and the nutrition, the sleep, the other things that they need.

Q. So if that's sort of the state of -- at like infants, how long in the lifecycle would you say that these pathways develop in a human until they're sort of mature?

A. We used to think it was 18 years of age, but it's closer probably to 25, how long the brain actually takes to develop, and that's based on a lot of neuroscience that came out of the '90s.

Q. And in addition to sort of this heightened sensitivity for very young infants, is there any other phase in life where something like this would also be more heightened sensitivity?

A. Yes. The transition through puberty, you either are exposed, no matter what gender, or you have hormones that drastically affect your development, your body, from the basic things we all think about in terms of sexual maturation, but we also know there are gender differences in the brain and that testosterone and estrogen and those chemicals during puberty

have a serious impact. So if somebody has already had their brain altered and not be able to develop properly up to that point, when you then hit puberty and all these other hormones start pumping, a lot of times it's very unpredictable, but we see are increased rates of mood problems in adolescence, as well as early substance use.

Q. Can you -- what is neurotoxicity?

A. It's essentially an overstimulation of a neuron to the point where it's damaged or even potentially ruptured and dies.

Q. And does that happen with these kind of psychostimulant substances?

A. With enough of the psychostimulant, but the argument really is around how methamphetamine, for example, is made. There are a lot of contaminants that go along with it that can also harm the brain, but even just with overstimulation of the neurons, you can get brain damage.

Q. And by that, you mean like physiological brain damage?

A. Yes.

Q. Like actual tissue?

A. Losses of normal cells, decreased connectivity of the neurons.

Q. Can you define sort of acute and chronic and end stage in terms of in terms of methamphetamine?

A. The typical course, if you have someone who has had a chance to mature normally, the acute exposure to methamphetamine

is when they do feel high, they feel euphoria. They feel special abilities a lot of times. And the reason they feel that is they get a significant increase in dopamine, and it's the delta from baseline to the new dopamine that creates that high.

As they move from subacute into chronic use, the delta gets less and less, and the person is trying to stimulate those same areas, but they're not getting the same response. So that's tolerance.

And then when you get to the end stage where you start to have brain damage or your body is totally dependent on it, you have withdrawal.

And then, in terms of methamphetamine, often the disruption in the dopamine and then the loss of sleep chronically can lead to the paranoid delusions, hallucinations, and then full on psychotic symptoms, like messages from the TV and the radio telling them to do things.

Q. Okay. You sort of talked about psychotic state or psychosis. Can you define for the Judge what you mean by that?

A. It's a state, regardless of what causes it, where the individual does experience perceptual distortions or beliefs that other people don't share. We call it a break from reality because the ideas are bizarre, and they don't conform to what most people around this person thinks is real. They believe their reality, and you can't talk somebody out of a delusion. That is really psychosis at that point, and that can happen from

mental disorders like schizophrenia or bipolar disorder with mania and psychosis or from severe substance use.

Q. So a person who is experiencing psychosis, do they have any self-awareness that they are having -- or that they're having these delusions?

A. Very little, especially when it begins in the teen years. They often are completely out of touch with reality and don't understand how bizarre the things that they're saying are.

Q. And is there some sort of either physiological or psychological reason why they don't realize that their way of thinking is not normal?

A. It's because of the brain pathways that are affected. For example, the prefrontal cortex has a role in discriminating what's real from what's not, and also insight into one's own situation is a more of a cortical process. And when you've overstimulated the midbrain with too much dopamine, it's as though the cortex is not able to control that any longer, and now the person is fully consumed and doesn't understand that what they're saying doesn't match up with what everybody around them believes.

Q. Is there a medical term for that or psychological term for that?

A. It's just usually psychotic disorder due to whatever is causing it.

Q. You just mentioned that this sort of process with

methamphetamine exposure is like schizophrenia. Can you describe for the Judge what you mean by that?

A. The same pathways are overactive in the brain, and the same medications are used regardless of whether the psychosis is in the context of schizophrenia or bipolar mania or methamphetamine. So right now, one of the main reasons people get admitted into a psychiatric hospital involuntarily is because of methamphetamine psychosis. The hope is that will wear off, but in the meantime, you treat them with the same antipsychotics that you would treat someone who has schizophrenia.

Q. And so when you say schizophrenia involves the exact same pathways as this methamphetamine, do you mean like physiologically, they are the same process?

A. Yes. There's evidence, for example, from neuroimaging where parts of their brain are affected.

Q. And so the only difference between schizophrenia and some kind of chronic methamphetamine psychosis is the origin of the problem?

A. I think that's fair to say, yes.

Q. Can you describe the -- as you understand it from the sources that you've talked about, from the foster care records, from speaking to Mr. Solis, from various different medical and psychological evaluations that have been done, both by defense doctors and government psychologists, your understanding of the

relevant medical history of Mr. Solis?
A. What I found is that the reports were remarkably consistent in finding that he was psychotic at that point.
Q. And "at that point," when do you mean?
A. At that point, meaning around the time of the events, and would have been just -- according to his mother, really August through December of 2020.
Q. 2019?
A. 2019. Sorry. And during that time, according to her report, contemporaneous reports, she would talk to him on the phone, and he was terrified, and he was disorganized. He had no means to support himself, but needed to -- felt like he was running away. So he was paranoid. He was delusional. And all those things are consistent with psychosis.

And then the retrospective interview asking him to look back on those symptoms many years later, he was able to describe them and had a story that was remarkably consistent when it came to the substance use, when it came to his childhood, when it came to his life experiences that led up to this time.
Q. And can you describe, when you say "his childhood," can you describe what you understand of his childhood from the interviews and from the foster care records?
A. Yes. According to his biological mother, she is hesitant to talk about some of these things, but she made it very clear by saying that methamphetamine was everywhere in the house where

he was a child, a small child, that there was active use going on almost constantly, to the point where for some reason he had at least one seizure. He was taken for emergency care and placed on an anticonvulsive medication for a month.

One of the things that his mother said is that, at that time, they were using methamphetamine and also playing video games for hours, upon hours, upon hours. And so as a five or six-year-old, he was in that environment and affected by most likely getting exposed to the methamphetamine and then also being exposed to the environment.

Then, when he was taken from that environment and placed in foster care, evaluated at Community Mental Health Centers, he was found to have attention deficit hyperactivity disorder, as well as post-traumatic stress disorder, and behavioral problems.

Q. Okay. So when you say that when he was a very small child, there's indication from his mother that there was -- she was actively using methamphetamine in the home everywhere all the time, was that also confirmed by the foster care records?

A. From what I could see, yes.

Q. And what was -- he was removed from her custody?

A. Yes.

Q. Why?

A. Neglect was certainly his mother's report. But from what he described, my guess is the environment was unfit. If they did a site visit, for example, if a social worker went to that

environment and those activities were going on, that would be a reason to remove.

Q. And so you said that, once he was removed from the home and placed into foster care, he was diagnosed with ADHD. Was he treated for that?

A. Eventually, he was treated for that, yes.

Q. What was the treatment for that?

A. A psychostimulant. So one of the most common treatments for ADHD is mixed amphetamines, such as Adderall, which is the trade name.

Q. And so once he was removed from the environment of his mother, he was then prescribed amphetamine?

A. Correct.

Q. In your opinion, based on the discussion we had earlier about the periods of sensitivity of the brain, what would be both the exposure in his mother's home and then prescription, amphetamine, what would that have, in your opinion, done to his brain during this time period?

A. One of the things that we don't understand fully is how ADHD, for short, occurs, but what we do know is that the treatment for it involves stimulants, not always amphetamines, but also methylphenidate, Ritalin. These are all stimulants, and it focuses the attention and calms down the behavior in a child, which is the opposite of what you would expect from a psychostimulant.

The brain, in the case of previous exposure, your dopamine pathways have already been altered. Now, if you are replacing or using a medication in controlled, regular amounts, as opposed to using a stimulant all day long all night for a long time, then you can get a balance back of having enough of a stimulant to function without leading to dysfunction, such as happens with addiction.

Q. So, in your opinion, was his exposure in his -- did the exposure to methamphetamine in his mother's home affect his brain pathway as a very young child, this dopamine sort of receptor pathway that we've been talking about?

A. Yes.

Q. And what would have been the effect of that on his brain?

A. In addition to changing the dopamine receptor numbers and distribution, it also may have led to poor nutrition. For example, one of the things about stimulants is they can decrease appetite. So at a key time where he needed adequate nutrition for his brain to develop properly, I don't believe that he was getting it. And so the effect of the environment on his brain development includes a methamphetamine exposure, but then also the neglect and other things that went along with it.

Q. And so when he was given prescription amphetamine, would that have played into damage that he already had in his brain or would it have helped damage in his brain? What would have been the effect of that?

A. The hope is that it would help balance the neurotransmission so that if he has a downregulation of dopamine receptors, you're replacing that with a prescription of amphetamine, and on a regular and consistent basis. Then that balance would hopefully allow him to do things like attend school, do homework, attend counseling sessions, and that was what happened for several years.

Q. Right. And so from the foster care records, did you see that while he was on prescription amphetamine, there was some balance in his life?

A. There were improvement in his behaviors, yes.

Q. And so what does that tell you about the damage that had been done to his brain that such regular doses of amphetamines sort of regularized his behavior?

A. Yeah. That is more consistent with the current treatment of ADHD, and that's one of the questions is, if you have a child with ADHD, they don't grow out of it. And so if they're going to stay on medications for many years to help the ADHD, you have to have it at a right dose and a right frequency so that it doesn't knock things out of balance again.

Q. And that's because, as you describe, they have fewer of these receptors or these receptors have retreated -- these dopamine receptors have retreated into the cells, and they're just not available?

A. And the whole brain has been sensitized.

Q. And when you say the "brain has been sensitized," what do you mean by that?
A. The exposure to a developing brain has multiple effects. I'm only talking about the dopamine system because it's understandable and directly relates to psychosis. But, in effect, it's -- all of the things that we just talked about lead to an abnormally-functioning brain. In addition to the dopamine receptors, it's the downstream effect on other neurons, so it's a network that's affected.
Q. And did he -- in his childhood, did the foster care records indicate that he continued getting prescription amphetamines?
A. I don't remember when exactly that stopped, but when he went back -- when he went to the custody of his grandmother, and according to his biological mother, they felt like he was on medications that he did not need, and so he was taken off of them at that time, so.
Q. Approximately what age was that?
A. I think 12, so right around there, 12 or 13.
Q. Okay. And so you had previously talked about how this puberty age was another highly sensitive time for brain development. What would have been the effect of removing him from prescription amphetamines at that time?
A. It could have been significant because his brain may have found some balance over those few years. His behavior was reflecting that he was improving, and not only taking away the

medication because now you have changed the receptor profile to a different balanced state, but you're also -- they also took away the structured living environment that he had that provided routine. It helped him to have accountability in that environment.

So it was the taking away the medications, but then also going back into the family environment where the treatment, from everything that I could look at and talked with Ms. Whalen about was they did not prioritize his treatment for his diagnosed mental disorders at all. So that's when he turned to drinking alcohol and then marijuana and then stimulants.

Q. And when you say he turned to these substances, why -- is there sort of a physiological reason why he would have turned to these substances?

A. I can say that there's a correlation between ADHD and substance use in adolescents, especially if it's untreated.

Q. And so his -- what about -- his exposure to methamphetamine and amphetamine, the sort of rewiring of his brain, would that have led to his seeking out these kinds of substances?

A. It increases the risk. In addition, the post-traumatic stress disorder increases the risk of, for example, alcohol use, substance use, and so you have combined ADHD and PTSD, and both of those are known for, if they're untreated, the individual will turn to substances.

Q. Okay. And is that sort of just what we would just call

addiction?
A. Well, if -- the addiction part of it, to me, is if you had had a normal upbringing, normal development, normal trajectory, and you are now 19 years old and you use methamphetamine and you get high and you then develop a pattern of use, then the current definition is that it has to be use for at least 12 months in order to be a substance use disorder. So if a 19 or 20-year-old who had no prior history of mental disorders, no prior history of neglect or abuse, started making that a part of their lives on a regular basis, then they would start changing their brain chemistry in a way that it can start to crave that stimulant.
So in the regular addiction world where if that is the case, they can still progress through acute to chronic to end stage, and they still can become methamphetamine -- they can still get psychosis from methamphetamine, even if they weren't exposed earlier in life, but it's a different situation when you know that these exposures happened, you know that brain has been sensitized. So it's a little bit different from addiction in my view because inside the -- in utero or as a smile child, you have no choice, and you're being exposed to this.
Q. And I think you've described that as sort of stimulant dependency of the brain. Can you just explain what that means?
A. Yes. In the diagnostic manual, the DSM-IV, we use terms "substance abuse" and "substance dependence," and they were confusing because people also talked about addiction. And so

what the DSM-5 has done is said any of these are considered a substance use disorder. So it could be alcohol use disorder. It could be cannabis use disorder, opioid use disorder, and then you have mild, moderate, or severe. And then, as you get over time and you have a physiological dependence, that's when you get tolerance and withdrawal. So we still can use the term "physiological dependence" because the body mechanically is dependent on it, but we don't use it in the psychological term. We call it a use disorder.

Q. Okay. But so, in your opinion, Mr. Solis's situation is different from sort of the normal, like, addiction kind of scenario that you described for what reason? Why is this different?

A. Because I believe his brain chemistry and the imbalance that resulted from early life exposure led to, when he was not being treated for his mental disorders as an adolescent, he was trying to feel better. He was trying to find something that his brain was craving. What ended up happening later on is that use continued in a way where, when it became chronic, he became psychotic, and then his judgment was impaired. He had lack of insight into what was going on, and he had a break from reality.

Q. And you've previously described in your report that, at that point, sort of once he reached this psychosis stage, which may have been longer, but certainly covered the period from August 2019 through his arrest in February 2020 -- I just lost

my train of thought -- his use at that point of methamphetamine was involuntary. Can you describe to the Judge why you say that?

A. The current thinking within the National Institute on Drug Abuse -- and there is a very succinct video by Dr. Nora Volkow, who is the director of the National Institute on Drug Abuse, and what she describes is the reward system getting out of control, such that the cortex or the rational thinking part of the brain can no longer put the brakes on, and so she talks about it in terms of loss of free will. We talk about it in the clinical context in psychiatry as the loss of cognitive and volitional control, and that was in that state of psychosis.

Q. And can you just describe for the Judge who she is and what her research covers?

A. Yes. She is a neuroscientist. She's the leading expert in the United States on substance use and addiction.

Q. And does her, like, scientific research involve this sort of this cortex and loss of function?

A. Yes. And that is important because, in the '80s, we didn't have all of this evidence, scientific evidence, from the decade of the brain, which is the 1990s.

Q. Yeah.

A. So she oversaw NIDA during the time where they took a lot of those findings from animal research, for example, and applied it to humans.

Q. Okay. So let's switch gears for a second.

What was medical science's understanding of stimulants and addiction let's say in the 1980s, in particular the early 1980s?

A. It was a very black and white way of approaching it and thinking that, for example, Alcoholics Anonymous is a very good example where what they say is if you have an alcohol use disorder, back then it would have been called you know alcohol dependence or alcohol abuse. Then one of the first tenants that they had was that you had to say your life had become unmanageable and you no longer had control, so you had to give it up to a higher power. So at that stage, when people had problems with alcohol, they were referred to an abstinence model, which essentially said either you are always an alcoholic, you are always dependent, and so they introduced themselves as I'm so-and-so, with my name, I'm an alcoholic. That, in the field of psychiatry, was really the only treatment for substance use disorder at that time was abstinence.

When we started learning more about harm reduction and the ability to treat substance use disorder with medications, we tried to reduce the impact and tried to acknowledge that there's a gray zone there that abstinence only works for some people but not for everybody. And so we've learned more about trying to address the underlying brain mechanisms.

Q. So would you say, in the 1980s, this idea of addiction and substance abuse was thought to be, by the medical field, a power

of the, like, will, like just a question of willpower?
A. Yes and considered a behavior.
Q. Right. Was there any understanding that it was actually biologically-based, that it had components in the brain, networks, the kinds of things that you've been talking about today?
A. The closest thing -- way to answer that is fetal alcohol syndrome has been around for a long time, fetal alcohol effect. And so people have known that if a pregnant mother drinks heavily, it will impact the infant. So that was the beginning of the neurobiological basis because that infant would not be considered born addicted. Right? People will say that, but the point is they -- there was no choice, and their brain was altered from that time. But we do understand much more about that now than we did then.
Q. Can you explain -- you mentioned the 1990s. What happened in the 1990s to sort of change the understanding that it's brain pathways?
A. It was actually labeled "The Decade of the Brain" by the scientific community, and there were billions -- I'm not sure how much went into that. But actually the funding for the National Institutes of Health increased, and in particular, we now have the National Institute on Drug Abuse, we have the National Institute on Alcoholism as well, which is a separate institute, and then we also have the National Cancer Institute,

which does a lot of work around nicotine or tobacco addiction, right, or substance use disorder.

So all of that infrastructure and all that spending led to findings all over the country at universities around how these substances affect rodents and then primates, and then eventually those findings were applied when we had imaging like magnetic resonance and PET scans, we started to study the effects in humans themselves and saw the impact.

Q. Okay. And what kind of -- describe what those scans are that you just mentioned?

A. It's -- for example, an MRI, a lot of people think of as you go into a big magnet and you try to hold still, and all these sounds are happening, and what's going on is you're using technology to develop a picture of the brain that is actually a 3D picture. But then we also have functional imaging, which shows changes over time. So it's not just a snapshot. It's more like a video.

Then a PET scan is where you actually put a radioactive isotope into your bloodstream, and it goes to the brain, and you have a scanner that picks up the radiation, and you can see functional changes within the brain that way over time.

Q. And so, you know, between now and let's say 1983, what -- how would you describe the change in the understanding, particularly in a case like this, where there's exposure as a young child from the 1980s?

A. Mm-hmm. The term now, and I'll quote Dr. Volkow, is the brain has been hijacked, and that that loss of free will, which she describes, or the loss of willpower to make the healthier choice, and now you're doing an automatic behavior where you just continue it without thought, that's the loss of cognitive and volitional control that we equate to loss of free will.

Q. In your review of materials related to the case, you know, sort of evidence, text messaging, videos, and things like that, what kind of evidence did you see that made you believe that that was the state that Mr. Solis was in that -- the psychotic state where he had no free will?

A. One of the most important things for me was a conversation with his mother because she was relaying information from that time. In my interview with him and with the others' interviews, they were all, as I said, consistent in finding that he did have psychosis. It's still retrospective. And so that's why knowing that at that time he was saying these bizarre things, he was acting strangely, for her to say this was very out of character for him, he had never acted like this before, all of those kinds of things, in addition to the just overwhelming number of texts and the -- it's stalking in the extreme, the control, preoccupation, that was his whole world was that psychosis and his delusions and hallucinations.

Q. So when you say the stalking conduct, do you mean stalking his codefendant?

A. Yeah.
Q. And the paranoia, what -- paranoia of her you mean?
A. Zero trust at all and that, from the post-traumatic stress disorder, is certainly -- part of PTSD is not trusting. But then also having had this prior relationship just before that and now being in a situation of thinking that she's doing bad things -- I'm talking about the events -- his whole life involved using methamphetamine and trying to effect this outcome, trying to follow the delusions that he had. So it was his whole preoccupation at that point.
Q. And what about, you know, it's kind of all over the record that, at that time, he believed he was Jesus, that he was trying to be inducted into the illuminati, these kinds of things. Is that, for you, an indicator also of this psychosis, this loss of sort of frontal cortex control?
A. Yes. These are very classic delusions. Hyper-religiousness, believing you're the higher power, those are classic for bipolar mania, as well as schizophrenia.
MS. BAGGETT: Your Honor, I think that's the only questions I have. Do you have questions that we can follow up with as well?
THE COURT: No.
Ms. Gregoire, cross-examination?
MS. GREGOIRE: Thank you.
///

CROSS-EXAMINATION

BY MS. GREGOIRE:

Q. Good morning, Dr. Layton.

A. Good morning.

Q. I wanted to start just to get sort of a baseline. You talked somewhat extensively about your interview with defendant's mother, Ms. Whalen. In fact, I think you said that was one of the most important things. That did not make your report, correct?

A. That was afterwards, yes.

Q. Okay. When was that?

A. May I check my notes in my --

Q. Yes. Absolutely.

A. October 15th.

Q. Okay. Of this year?

A. Of this year, yes.

Q. Okay. And I guess when you interviewed Ms. Whalen, I assume that was a telephonic interview; is that correct?

A. Yes.

Q. And what did she tell you that you found informative? What did she tell you about Mr. Solis?

A. Primarily that he was very scared, that he was confused, that he was acting bizarre.

Q. And did she give a timeframe for that?

A. Yes. August through November really was the time that she

was focused on of 2019.
Q. Okay. Of 2019?
A. Yes.
Q. Okay. And how was it that she was able to observe him as scared, confused, acting bizarre?
A. He called her repeatedly.
Q. Okay. Because he did not live with her at that time; is that correct?
A. Correct.
Q. Okay. So she observed these things via phone calls?
A. Yes.
Q. Okay. And then she talked to you about his childhood and meth exposure to him during his childhood?
A. Yes.
Q. That's my understanding. Okay.
And she said to you, "Meth was everywhere"?
A. That was a quote, yes.
Q. Okay. Did you confront her with all of her statements to CPS and other investigations conducted by CPS that suggest meth was not everywhere?
A. Did I confront her with that?
Q. Yes.
A. No, I did not.
Q. Did you note that that was a wild discrepancy from what was described in those records?

A. No. I'm not sure exactly -- do I -- could you repeat the question?
Q. In the records, it's your understanding the children were taken away because the mom was being neglectful and was also under the influence of methamphetamine, correct?
A. Yes. That is my understanding.
Q. And at that point, when she was spoken to, she said she didn't have a problem, used it recreationally, could stop whenever she wanted, correct?
A. When she -- back then?
Q. Yes.
A. You're talking about -- yes.
Q. And she did in fact stop using methamphetamine as indicated by her years of clean drug tests, correct?
A. Intermittently.
Q. Well, she went back to meth, I believe she says, one time. Did you see something else in there that I did not see?
A. The way she phrased it to me was, "I'm an addict. It almost killed me," and that he -- people who were doing it in the home -- "people were doing it in the home. It was everywhere." She said that she was taken -- he was taken away because she was "neglecting my kids," and she described him growing up in that environment with the people who were using methamphetamine.
Q. Okay. And who were the people?

A. Not by name. I didn't ask any specific names.
Q. Okay. But you know from the records that she at one point lived with a boyfriend when the children were there, and that's the only person she's described as living with; is that correct?
A. I don't know that for sure.
Q. Okay. And then she described using methamphetamine when she was pregnant with the defendant?
A. She did not admit that.
Q. Okay. Where did you see that?
A. I -- what she said was that, when she was pregnant with him, that methamphetamine was still in the environment.
Q. Okay. So it was -- she may have ingested it secondhand at some point that she was pregnant with him; is that correct?
A. My statement is that it was in the environment when she was pregnant and early in his life.
Q. Okay. And you understand that defendant was removed from her care at about age five; is that right?
A. Yes.
Q. Okay. I think I'm clear on that. I want to go -- take a step back and go to some more general discussion points again just to establish a baseline.

What is your definition of voluntary as opposed to involuntary intoxication? You said defendant's intoxication was involuntary. I'm asking as a general matter, not speaking to defendant, when you, as a doctor, are looking at this, what do

you determine -- use as a definition for this is involuntary, this is voluntary?

A. We don't technically define it that way. I think that's a question of language. So, for example, if I found that someone had a substance-induced psychotic disorder, what I'm concerned with is: What is the substance and what is the severity and what is the chronicity? And so when we talk about voluntary versus involuntary, it's more in the way of treatment.

Q. Okay. How do you define "addiction"?

A. Use of substances in the face of negative consequences, usually involving compulsive use, which means that, like I said, you have to have a 12-month pattern that's clinically significant and causes duress. It has to interfere with relationships, interfere with work or school, interfere with parenting. That's how you make the diagnosis, and then there are 11 different criteria for determining the severity of addiction, which technically would be a use disorder.

Q. And some of those adverse consequences that you indicated that accompany addiction, right, use of a substance in the face of negative consequences, and some of those adverse consequences are psychological, correct?

A. Yes.

Q. And some of those consequences are physiological, correct?

A. Yes.

Q. I want to talk a little bit about defendant's childhood,

but it's my understanding as sort of an overarching theme that because defendant had methamphetamine around him up through the age of five when he was taken away from his mother and because he was prescribed Adderall, which we assume he used, he was more susceptible to methamphetamine addiction; is that right?

A. Can you rephrase that?

Q. I don't know that I can.

In terms of why it's relevant that he had methamphetamine around him when he was little, why it's relevant that he was using Adderall and then came off of Adderall in his sort of mid-teen years, preteen years, that is relevant because it made him more susceptible to the meth that he used, the elicit methamphetamine that he used later, correct?

A. Yes.

Q. Okay. I wanted to talk a little bit about his childhood. I guess I want to talk first about just the Adderall. Having reviewed those records -- and you reviewed the records from California, correct?

A. Yes.

Q. Defendant told you during his interview with you that he was on a cocktail of medications, he was taking a handful of medications every day from ages five to 13, right? That's what he told you?

A. Yes.

Q. And that's not true, is it?

A. I would have to have those records in front of me to see. His mother also said he was on five medications, and so I think that's important.

Q. But he wasn't living with his mother during that timeframe, correct?

A. Correct.

Q. And the records reflect that he was prescribed Prozac, correct?

A. Yes.

Q. And the records reflect that he was recommended for Adderall in about 2004, and he may have ultimately taken it, but then in 2005, he agrees to a clinical trial of Adderall, so we know that he is then going to take it because he agreed to it, right? And then it's listed on his medications for a year, and then in 2007, it listed him as only being prescribed Prozac; isn't that right?

A. I would have to look again.

Q. Is it -- does it make a difference to your analysis if he was only using Adderall for about a year or would that not impact?

A. It would make a difference because if his brain was sensitized and Adderall actually helped with the balance of dopamine and that were taken away, then he might be seeking out something to regain that balance.

Q. And so if it was taken away, it would have been taken away

by 2007 because that's when it lists only Prozac, correct?
A. There were -- I would have to have the records in front of me because there were multiple evaluations by different people. Some were prescribing medications; some were not. And so, to me, just like the example with his mother, the reason she told me he was on five medications is she and her mother took him off of those when he was taken out of foster care.
Q. And he was taken out of foster care to your understanding in 2008 on June 19th?
A. I would have to check.
Q. Okay.
A. If you are telling me that's what it's -- that would make sense.
Q. And at that point, she had him on no medications, per your interview with her?
A. Correct.
Q. Okay. And then he had also mentioned to you that he was on Abilify at one point, and that's not true, correct? He was never on any antipsychotic medication while he was in foster care?
A. In jail, right.
Q. Can you --
MS. BAGGETT: To correct the record, because you -- Alison, you said "in foster care" and he said "in jail." Can you correct that question?

MS. GREGOIRE: Yeah. I'm actually going to pull the report because that's not what it says.

Q. (BY MS. GREGOIRE) Okay. And so what he said is he remembered, at some point, Daniel was a patient at Bayview Behavioral Hospital in San Diego. Then it goes on to say, "He described medication from ages five to 13 of all types. I was on a cocktail of medications every day. He remembered being treated with ADHD medications. The ones that I mentioned to him sounded familiar. Those were Ritalin and Adderall. He had also been treated with Prozac and Abilify."

Is that what he said to you?

A. I don't have specific dates, but you mentioned Abilify, aripiprazole. It looks like to me that was November of '22 to January of '23.

Q. So he had no history of antipsychotic medication prior to coming into the prison system; is that correct?

A. I would not say that. I don't know that.

Q. Okay. I want to talk to you about the difference, to the extent there is one, between addiction and physiological dependence, because we spoke about this earlier, that addiction in fact does entail a physiological dependence, right?

A. It depends on the level and severity of the use disorder, right? So I think that's an important distinction is if the brain -- the cortex is physiologically dependent on a substance and, in its absence, has cravings for that substance, it's

because the brain pathways have been changed. So you could say that's physiological.

Q. Okay. So if a person -- maybe that was a poor turn of phrase. If a person has a driven craving for a substance, that can be described as a physiological dependence?

A. Yes. At that point, I believe their substance use disorder would be severe enough that now they have a physiological dependence.

Q. Okay. And a physiological dependence is when they're -- you described it as a craving just a moment ago, but there are consequences to your body when you're not taking the drug; is that right?

A. Yes.

Q. Okay. And a person who is addicted, that physiological dependence can vary, is it fair to say, how that manifests based upon the substance that they're addicted to?

A. And their own genetics.

Q. And their own genetics?

A. Mm-hmm.

Q. And so alcoholics get DTs?

A. Correct.

Q. Is that an example?

A. That is an example.

Q. What about I burn through just a tremendous amount of coffee and get a headache when I don't have it. Is that an

example of a minor physiological dependence?
A. You bring up a very important example because there is, in the DSM-5, caffeine withdrawal syndrome, but there's not caffeine use disorder. So --
Q. What does that mean to you?
A. Well, it means that the world uses coffee and tea so much that what's abnormal? You know, what's normal versus abnormal? But there's no doubt that because there is this syndrome characterized by headaches and other things, that there is some kind of physiological dependence, yes.
Q. Okay. And, well, just going into the withdrawal symptoms, opioid addicts can be in real trouble due to their physiological dependence; is that right?
A. That's correct.
Q. And you have -- I apologize, Doctor, and I should know this from your CV and I don't. Have you worked with people who are in recovery?
A. Yes. I've been a medical director for two different opioid treatment programs.
Q. And those are people who are still -- they've chosen to go into recovery, and they are going to still have to deal with some physiological ramifications of the choice to step away from that drug; is that correct?
A. They're on a medication for -- to aid recovery.
Q. Your people are, but that's not true of all people, is it?

A. No. But I think that's why it's important to be specific in terms of opioid use disorder -- why do so many people on methadone, for example, still use methamphetamine?
Q. Okay.
A. That is a thing.
Q. And so there's still -- and you can pick really any drug, but it's fair to say -- have you worked with people who are in confinement?
A. Yes.
Q. And they're being taken off that drug right away, right?
A. You're talking about opioids?
Q. I'm talking about methamphetamine.
A. Methamphetamine, yes.
Q. And they're going to suffer some physiological symptoms as a result in most cases, correct?
A. Yes.
Q. And a person who chooses -- an alcoholic who chooses to go to treatment is going to suffer some physiological effects from that decision to abstain from the -- from the substance to which they're addicted?
A. And psychological --
Q. And psychological effects?
A. -- effects as well. I think that's important to point out.
Q. Yes. But it is possible -- in other words, it is possible -- someone is not sort of damned if you will if they

start using one of these -- if they develop these physiological responses to the ingestion of the drug, it is possible for them to stop using the drug; is that correct?

A. It is possible.

Q. I wanted to talk to you just briefly -- incidentally, I'm going to circle back for just one second. You -- because you work in substance abuse disorder, is it fair to say that most of your clientele have had some adverse experience that predated their use? They either had a bad childhood or some other thing that you could say at least made them more susceptible to using the drug?

A. The way I would answer that in terms of the opioid use disorder population is that about half of them actually were prescribed medication for a legitimate medical issue, and they got dependent physiologically on opioids, and they did not have bad childhoods or early problems. So, for example, a car accident or a construction worker who hurt their back, and then they got prescribed a lot of opioids, and then they get out of control.

Q. And so -- and the Court obviously has its own experience, having dealt with a lot of people who are charged with drug crimes. But all the people that you work with were initially prescribed the medication before they started using any sort of an opioid?

A. Not all of them. No. That's what I was going to say is

about half have a severely disrupted family history and were exposed to bad things early in life.

Q. Okay. So about half of those. And do you work with any other substance addicted type people beyond opioids or is that sort of your specialty?

A. No. I work with all types, and I do research now more than clinically.

Q. And so then when you take a step back from opioids and talk about, for example, methamphetamine, another very serious drug, I think you would agree, what about those people? What percentage of them had some sort of an adverse childhood experience or something that made them more susceptible to drug use?

A. It's tough to put a number on it because you're talking about a small percentage of the total population. Okay? So arguably less than one percent of the population. So if you look at those who have a methamphetamine use disorder and you find out were you diagnosed with attention deficit and hyperactivity disorder early in life, that is common.

Q. Okay. And there is still -- there is still some choice, even as amongst those groups, I guess so to speak. In other words, I don't think that you're here today, but I want to clarify. But I don't think you -- you are not here today to say if you used Adderall and you come off the Adderall, you're going to be a meth addict, that's what's going to happen, right?

A. That would be an extreme statement, yeah.
Q. That would be an overstatement, correct?
A. That would be an overstatement.
Q. And not what you're saying today?
A. It's not what I'm saying, no.
Q. And then there was a line in the supplemental report, which you didn't sign, but I just wanted to check my understanding on that, that said that "The defendant has suffered from psychosis from an altered brain that has continued while he has been incarcerated for five years." Are you proffering that he's maintained himself in a state of psychosis for the past five years?
A. It has diminished.
Q. Okay.
A. Which is typical of methamphetamine-induced psychosis over years. We have neuroimaging that shows changing in the brain out to two years after someone has stopped. Okay? So what it shows in the neuroimaging is that methamphetamine can change the number of neurons, and it can also increase inflammation in the brain. That all takes time to heal. And so when I interviewed him in July, he was gaining insight into the fact that he may have not been experiencing the same reality as everybody else. So he was gaining insight into it. And the example of that would be that he thought he was doing what God told him to do, but now he says maybe it was Satan.

Q. Do you believe that he is still undergoing -- that he is -- during his time with you, has he exhibited or demonstrated to you that he is psychotic?
A. In very low grade terms because he described, for example, waking up in the morning and thinking these same thoughts, but now being able to, quote, talk himself out of it. Now, you know, he can say "I don't think those things were real, even though, at the time, I was convinced they were." And I think that's the result of being incarcerated, not having further meth exposure, and that his brain hopefully is healing.
Q. Okay.
MS. GREGOIRE: Your Honor, may I have one moment to consult with cocounsel?
THE COURT: Yes.
MS. GREGOIRE: Thank you.
That's all I have at this time, your Honor. Thank you.
Thank you, Dr. Layton.
THE COURT: Dr. Layton, I had a question. Where is he getting the methamphetamine? He's voluntarily going out to get it, isn't he?
THE WITNESS: Well, I think he's following an automatic urge that what we would say now he doesn't have the willpower to stop going to get it.
THE COURT: But he didn't have a job at the time, so where is he getting the methamphetamine?

THE WITNESS: I am not sure how he's getting it, whether he was doing it in trade, whether he had other money sources.

THE COURT: But you -- you would say that that's voluntary conduct on his part to go out and seek methamphetamine to use it?

THE WITNESS: I think that is the rub, really, is that what the experts and what the field is saying is that it's a loss of free will, and he's going compulsively to get it automatically.

THE COURT: All right. Any redirect?

MS. BAGGETT: No, your Honor. Thank you.

THE COURT: All right. You can step down. Thank you. Do you have any argument, Ms. Baggett?

MS. BAGGETT: Your Honor, just briefly, and I'm happy to submit in writing, too, if you want further sort of legal analysis.

But the way that I see this, your Honor, is that there are very, very few cases on this question of, under the Insanity Defense Reform Act, the fact that voluntary intoxication cannot be a defense, and keeping in mind that that act came in 1983 and was signed off on by the American Psychological Association, the very association that Dr. Layton was talking about, now has a completely different perspective on these issues. And that nearly all of the cases that we have interpreting this idea of

voluntary versus involuntary intoxication, if you look at the dates on those, your Honor, they're all from the 1970s and '80s, and in fact, a lot of them actually even predate the act.

So I think that what we are not trying to argue here, your Honor, and I think the government is going to try to suggest that there's some kind of slippery slope here that, well, if you buy this argument that he was so intoxicated, he had no free will, then you're basically opening the door to everybody who takes methamphetamine and has psychosis can go out and commit any crime they want and not have culpability. That's not what we're saying here, your Honor.

And as Dr. Layton very succinctly described, that's different. You know, once you have an adult making those decisions versus someone like Mr. Solis, who the origins of all of this were in his infancy and exposure to methamphetamine involuntarily when he was an infant, and then as a child being prescribed -- you know, as an eight-year-old, nine-year-old, you know, he's not deciding whether he -- and he's in foster care, he's not making a decision over whether he takes prescription medications or not. That in that circumstance where the origins of the brain defect come about through involuntary exposure to these substances to the point where his brain is then dependent and build to the point where he has such psychosis that he's -- you know, the decision over whether to seek out meth, to find money for meth, to literally put it in your mouth is not a

product of free will. That's different than saying, oh, somebody who has a genetic susceptibility to addiction, and then when they're an adult or later in life, decides to take this stuff, we're drawing a line between those two, your Honor, a legal line between those two.

And I think to say that we can't use the change in science since the 1980s to help us understand and appreciate that there are differences and that they are biologically based is like saying that we should never have changed our legal perspectives once we discovered DNA. I mean, it's really sort of, you know, once science gets to a certain point, surely we have to take that into account and to accommodate our understanding of the legal side of this to take that into account.

And I think there's -- you know, to say that -- I mean, really we're -- the question before your Honor is, you know, is this a type of case where maybe we want to consider lack of culpability or a difference in culpable level. That's really the question.

And I think if you look at other examples, even in the old case law from the 1980s, of examples where it didn't necessarily come in in cases but are constantly routinely recited as, oh, well, we would agree that this would be allowed if it ever came up. And those are things like somebody voluntarily takes a drug, and it turns out that it happened to be, like, they had hypersensitivity to it or something or someone slips a drug into

your drink, and you don't know about it, and therefore, we would -- might recognize that. I would say that if you compare the level of culpability of people in those kinds of hypotheticals to the level of culpability of somebody like Mr. Solis, whose brain was so altered and rewired involuntarily throughout his entire childhood, I think that his situation is just as arguable as those types of hypotheticals, your Honor.

THE COURT: All right. Thank you.

Ms. Gregoire, do you have rebuttal?

MS. GREGOIRE: Very briefly.

Your Honor, nothing that Dr. Layton said today does anything to disturb the previous findings of this Court, nor does it disturb the previous arguments set forth by the government.

What I heard Ms. Baggett arguing essentially is that a lot has changed since 1983, and she elicited as much. But to suggest that this Court is therefore free to disregard the law because it was established at a different point in time I think completely lacks footing.

What we do know is the law is that addiction is not enough. That you are going to suffer an adverse ramification in terms of physiologically or psychologically because you've developed an addiction to the drug, that is not enough to make it involuntary. And voluntary intoxication cannot serve as the precursor, cannot serve as a basis, cannot serve as a

contributing factor to insanity.

And, your Honor, in this case, as Dr. Layton testified, there are people who have addictions who do suffer physiological effects, whose brains have been, quote, unquote, rewired such that they are going to suffer effects when they stop the drug. And they go to his treatment program and they come before this Court and they go to jail sometimes, and those people stop using. There is still a volitional choice to use, as opposed to -- even once one is addicted, there is a volitional choice to use, as opposed to suffering that physiological effect.

And, your Honor, the case law is very clear. An addiction will not serve to take something out of what would be voluntary intoxication and make it involuntary intoxication, and the reasons for that were explained pretty well by Dr. Layton. At least half of his patients have as a precursor to their -- to what ultimately becomes their substance use that they had a bad childhood. A good portion of the balance of his patients have as a precursor that they were prescribed a drug that ultimately generated an addiction that they then had to feed. That does not serve to make all of that voluntary use involuntary because they were going to suffer a physiological effect if they stop.

And, your Honor, I believe the case law is clear on this, but I can yield to any questions from the Court.

THE COURT: I have no questions.

MS. GREGOIRE: Thank you, your Honor.

THE COURT: It is the decision of the Court to not allow the insanity defense. The defendant's use of alcohol or drugs was volitional in this case.

I've read all the foster care, and I've read Dr. Layton's written report and heard all his testimony, but I still find under federal law that it's volitional, and using drugs voluntarily -- drugs or alcohol voluntarily does not establish an insanity defense.

That's the ruling of the Court.

At this time, I need, Ms. Baggett, you and your client to stay in the court. I'm going to have an ex parte hearing with you on a matter that you filed. And everyone else is excused from the courtroom.

MS. GREGOIRE: Thank you, your Honor.

(Proceedings concluded on October 31, 2024, at 11:28 a.m.)

WITNESS INDEX

EXHIBIT INDEX

C E R T I F I C A T E

I, CRYSTAL L. GONZALEZ, do hereby certify:

That I am an Official Court Reporter for the United States District Court for the Eastern District of Washington in Spokane, Washington;

That the foregoing proceedings were taken on the date and place as shown on the first page hereto; and

That the foregoing proceedings are a full, true, and accurate transcription of the requested proceedings, duly transcribed by me or under my direction.

I do further certify that I am not a relative of, employee of, or counsel for any of said parties, or otherwise interested in the event of said proceedings;

DATED this 1st day of November, 2024.

CRYSTAL L. GONZALEZ, CRR, RPR
Washington CCR No. 2955
Official Court Reporter
Spokane, Washington